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The procedure for mobilization has been standardized and was thought to be coordinated well between the various departments. Upon instituting a clinical trial utilizing plerixafor for patient and healthy donors on the same day as pheresis, we were presented several opportunities for improvement of our patient experience as well as our communication between departments. In the clinical trial, Plerixafor is given in an infusion center 4 hours prior to apheresis. During this 4 hour break, the patients left the infusion center but were noted to have side effects such as fainting or explosive diarrhea. This left the patient/donor with no medical connection and the pheresis department feeling ill informed about the patient/donor. The transplant team at a large comprehensive cancer center identified the need to hold a rapid improvement event (RIE) related to our mobilization procedures. An RIE is a tool utilized within Lean Management Principles. It is typically a 3-5 day meeting that brings frontline workers together to identify creative solutions for a focused problem. We called our RIE "Creating the ideal donor/patient experience" with the goal to improve the donor/patient experience as well as improving interdepartmental communication.

A systems engineer was called to be the RIE team leader. The team included representation from pheresis, transplant nurse coordinator, both sites of infusion and leadership. The group spent 4 hours identifying the problems surrounding mobilization. Areas identified as needing improvement included; the mobilization orders, the handoff process between the infusion center to the pheresis department and back, the consistent evidenced based education for patient symptoms related to mobilization as well as several minor logistical communication processes. The team then was assigned "homework" and reconvened on several occasions.

Outcomes of the RIE: Patients now stay within the infusion center until they are ready to go to pheresis and at that time they are escorted by an MA after being deemed stable; the development of a formal written handoff for the pheresis department from the infusion center; the creation of new mobilization orders that are significantly easier to understand by all areas; the development of a quick reference sheet for nurses outlining typical side effects and interventions specific to the mobilization period. Most importantly, we have had no patients incur side effects outside of medical care since initiating this process. We continue to review our process and make changes on a regular basis.

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Home Sweet Home: Our Experience Providing Immediate Post-Transplant Care to Patients in Their Home

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Hematopoietic stem cell transplantation (HSCT) is a rapidly evolving science. Care of the patient undergoing any type of HSCT requires the transdisciplinary team to continuously evaluate the needs of the patient and family utilizing new evidence and best practice. Within our Division we have implemented a protocol that allows for patients undergoing HSCT to receive their immediate post-transplant care during their pancytopenic phase of recovery at home provided they live within a 90 minute drive of our clinic. Our first participant received Zevalin® and BEAM chemotherapy followed by autologous stem cell rescue for DLBCL and was discharged home following stem cell reinfusion. Daily visits in the home were initiated on day +1 and continued through day + 22. During that time the participant required one overnight admission to our inpatient unit for management of febrile neutropenia, and two visits to our outpatient daily clinic due to unavoidable operational barriers to providing care in the home. There were 17 midlevel provider visits which lasted between 30-90 minutes and 14 RN visits lasting between 2 and 4 hours. Antibiotic infusions (# of days=11), electrolyte supplementation (# of days=12), intravenous hydration (# of days=4), blood transfusions (# of PRBC=2, # of platelet=7), filgrastim (# of inj=9) and documentation were all completed in the participant's home by the nurse using internet based technology. Participants used an internet based audio visual communication tool to communicate daily with the attending physician and all other ancillary services. It is our hypothesis that fewer gastrointestinal and infectious complications will be observed, there will be a decrease in the cost of the procedure, and participants being treated in their home will report both higher functional and subjective QOL scores over the course of treatment when compared to the a control population. Successful continued execution of this model will require partnership with managed care organizations, institutional transfusion, IT, and pharmacy services as well as the development of a staffing model to support this innovative method of care delivery for the unique HSCT population.

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Importance of Preceptor Competency and Its Role in Orientee Satisfaction and Retention

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The role of nursing preceptor has become increasingly challenging especially in acute care settings such as Adult Blood and Marrow Transplant. Preceptors must possess a variety of skills to meet the needs of their orientees especially the new graduate nurse. Healthcare organizations can spend upward of $50,000 on an individual nurse's orientation. Research has shown that "the key to improving recruitment and retention is the quality of an organization's orientation program, and a well-prepared preceptor is key to ensuring the quality of the unit-based orientation". *(NNSDO Trendlines, July/Aug '09).* Two years ago several trends were noted in our unit's new graduate nurse population. The first was an increase in the extension of unit based orientation. The second was an increase in new graduate nurses leaving the unit within the first year of employment. For those reasons a Performance Improvement Task Force was created and a preceptor